Kansas Health Policy Authority

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KHPA Medicaid Transformation Grant Proposals

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Background on Transformation Grant Request

States will receive $150 million over FFY 2007 and FFY 2008 to fund research and design of ways to transform their Medicaid systems, to the increase quality and efficiency of care. Funds for the Medicaid "transformation grants" were authorized by the Deficit Reduction Act of 2005 (DRA) and are aimed at state adoption of innovative systems to get more value out of the money they spend providing healthcare to their citizens who are low-income elderly, children and people with disabilities.

CMS is encouraging states to look at particular areas of program operations for improved efficiency, including methods for:

- Reducing patient error rates (electronic health records, clinical decision support tools or e-prescribing programs).
- Improving rates of collection from estates of amounts owed under Medicaid.
- Reducing waste, fraud, and abuse under Medicaid, such as reducing improper payment rates.
- Reducing Medicaid expenditures for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through education programs and other incentives
- Improving coordination of care through care management programs and other steps to prevent complications and duplicative or unnecessary services
- Implementation of performance-based payment programs to provide rewards and support for high-quality care
- Implementation of programs to promote personal control over services, with greater emphasis on prevention steps
- Improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems.
- Implementation of a medication risk management program as part of a drug use review program

While the DRA set aside $75 million for each of FFY 2007 and FFY 2008, the grant fund solicitation will be for both years at one time. All states will be eligible for a grant and grant amounts will be variable dependent upon the number of states that apply.

No state matching funds are required for these special grants. The submission deadline was October 2, 2006, with an award announcement expected sometime in early November, 2006.

Description of Proposals Submitted

1. e-prescribing Solution Pilot: Sedgwick County

The State of Kansas seeks to transform the healthcare delivery system in Kansas Medicaid through the use of health information technology, specifically e-prescribing, to improve quality of care, patient safety and cost-effectiveness of care delivery. Kansas' proposes to build upon an existing community health record pilot project to make available an e-prescribing solution to every prescribing provider participating in the pilot, as well as rural providers in a bordering county.

Electronic prescribing can reduce adverse drug events, improve medication compliance, improve preferred drug list compliance and generic prescribing rates, and control costs by providing the prescribing physician access to relevant drug and patient information at the time of prescribing. The project budget for 2007 is $472,344 and for 2008 is $218,034, for a total project budget over the two years of $690,378.

2. e-prescribing Pilot Project: Douglas and Shawnee Counties

Kansas proposes to address the continued escalation of prescription drug utilization and costs through the use of an e-prescribing tool incorporated into the Medicaid Management Information System (MMIS). The tool will incorporate existing drug data, patient prescription claims history, clinical editing and auditing, the Kansas Medicaid preferred drug list (PDL) and prior authorization criteria, making all of this information available to the prescriber at the time of prescribing. Through the use of this technology, Kansas Medicaid's goals are to reduce adverse drug events, improve patient medication compliance, increase PDL compliance and control prescription drug cost growth by providing prescribers with critical drug and cost information at the point of prescribing.

Efficiency and effectiveness of the Kansas Medicaid program will be increased by automating the prescribing process. This automation will reduce time spent clarifying prescription orders and manually completing prior authorization requests, thus allowing for more time to be devoted to the provision of quality health care. Overall project outcomes are reduced drug therapy related problems, improved system efficiency, and improved quality of care.

The e-prescribing tool is web-based and uses the existing Kansas Medicaid website and MMIS. No hardware or software purchase is required by the providers. Once developed and integrated into the MMIS, the tool is easily replicable throughout the state and other states by training providers to access and use.

Total project costs are $680,834 in 2007 and $194,814 in 2008, for a combined total budget over the two years of $875,648.

3. Utilizing Technology to Identify High Risk Beneficiaries and Provide Interdisciplinary, Intensive Medication Risk Management

Medicaid has long grappled with ensuring high quality, cost-effective pharmaceutical care for its beneficiaries. While each state Medicaid program operates a mandatory retrospective drug utilization review program, retrospective drug utilization review has been deemed ineffective and more effective tools for managing prescription medication use and costs are needed. With the implementation of Medicare Part D, state Medicaid programs have seen dramatic declines in utilization of and expenditures for pharmaceutical benefits and must reconsider effective management of their prescription expenditures, particularly for the disabled and other high risk populations. Medicaid-enrolled disabled adults actually incur higher per user prescription drug costs than aged program enrollees, but there is a dearth of information on the medication-related problems and needs in this population. However, given their generally poor health status and functional limitations, it is quite likely that they face many of the same problems as older persons.

There are a number of barriers to access to quality health care for disabled persons including poor coordination of care across clinicians. Because of their close relationships with beneficiaries, case managers are in a valuable position to help resolve medication related problems when partnered with pharmacists. We propose coupling a technology-based data system to identify medication-related problems with an individualized, interdisciplinary approach consisting of pharmacists, case managers, and local physicians to tailor interventions to the needs of the beneficiary to resolve them. The goals of this project are to utilize data

to target high-risk individuals with medication-related problems for intensive case management and monitoring, including payment to pharmacists for medication therapy management. This interdisciplinary approach and targeted effort to improve prescription drug therapy should translate into long-term benefits through reduced medication errors, improved compliance, enhanced therapeutic outcomes, and subsequently lowered health care costs for Medicaid. A cost-effectiveness analysis will be conducted to determine the benefit of this intervention. The total proposed budget, including the systems applications is $ 2,157,166 over the two year period. Alternatively, the systems application could be removed from the project, while keeping the academic detailing and medication therapy management components intact for a total project budget of $ 907,116.

4. Performance, Payment, and the Transformation of Medicaid

Health care costs are rising and quality is uneven. Payors are seeking solutions and Pay for Performance (P4P) programs are increasingly popular. They pay doctors to follow established guidelines in the processes of care they provide. Though most programs are private, Medicare is funding demonstration projects and several state Medicaid programs are considering P4P plans. The idea of P4P appears to make sense but there's little evidence that current plans improve quality or reduce costs. These plans face three problems. 1. - Definition of quality. For doctors, quality is a ceiling of performance seen in a gifted teacher or an admired colleague. For payors, it is a floor below which the processes of care must not fall. This cultural difference generates confusion and mutual suspicion – a poor foundation for any policy initiative. 2. – Measurement of quality. Should measurement target patient outcomes, clinical processes, adoption of information technology, patient experience, or some combination of them all? A complex definition requires complex measures. And as multiple payors deploy these unwieldy programs, administrative complexity worsens, the doctor's time is diverted, and, ironically, quality suffers. 3. – Focus. Conventional P4P focuses far more on the doctor than the patient. This reinforces patient passivity and misses a chance to strengthen the patient-doctor relationship, particularly fragile in Medicaid. A successful P4P program should be simple, its measures of performance should target the patient, and its payments should strengthen the patient-doctor relationship. The Kansas design contains four elements. 1. – Learn from separate focus groups of doctors and patients which payments work best. 2. – Measure only five indicators (Body Mass Index, Blood Pressure, Hemoglobin A_{1c}, Walking Fitness, and Asthma) and define performance as improvement in those indicators. 3. – Pay patients to enroll and pay doctors to advise them. 4. – Pay patients for performance and share that payment with their doctors. Projected budget for the first 2 years would be $589,700. This program nurtures individual responsibility and the patient-doctor relationship. It will redefine P4P and help to transform Medicaid.

5. Payment Error Rate Measurement (PERM) Assistance:
Policy Centralization and Standardization and Oversight and Quality Assurance

KHPA wishes to use grant funds to organize and catalog KHPA Medicaid policies and procedures, which are not currently organized in a manner that allows for searches or aggregation. This lack of organization presented significant issues during the FFY 2006 Payment Error Rate Measurement initiative. KHPA has not been able to provide the CMS contractor a complete set of all policies that are required for the study. A variety of other projects, as well as day-to-day operations, required extensive effort to obtain necessary policies.

CMS will benefit from this grant, as will Kansas. Timely, accurate access to policies will remove numerous problems encountered in daily operations as well as special projects such as PERM. It will also resolve inconsistencies, where they might exist, with our State Plan or with other state agencies.

The proposed budget to organize and catalog KHPA Medicaid policies and procedures is as follows:
$374,400 FFY 2007, $128,600 FFY 2008

KHPA seeks to create an electronic, web-based, centralized, and standardized catalog system for all current policies. The system will be updatable to integrate any new policies. The desired outcome is to create a system that can be efficiently and effectively used by staff for day-to-day operations as well as special projects.

CMS implemented PERM to measure improper payments in the Medicaid program and the State Children's Health Insurance Program (SCHIP). PERM is designed to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300). CMS is using a national contracting strategy, consisting of three contractors, to perform statistical calculations, records collection, and reviews of state Medicaid fee-for-service

(FFS) claims throughout FFY 2006. KHPA participated in the PERM pilot study. KHPA was selected to participate in the PERM audit in FFY 2006. Please note that while all tasks proposed in this component relate to the current Medicaid PERM study, tasks occur in FFY 2007 and FFY 2008.

CMS will benefit from this grant, as will Kansas. Further assistance with the remainder of this year's PERM project is critical. That work will entail monitoring results, determining best practices, submitting a corrective action plan, and assessing quality improvements. These activities will strategically position Kansas for excellent PERM performance in FFY 2009 and future cycles of PERM.

The proposed budgets for technical assistance with PERM are as follows:
$70,000 FFY 2007

The project goals and outcomes are fully documented protocols, policies and procedures for conducting future PERM studies, including best practices and lessons learned. KHPA also seeks assistance in the general oversight and quality assurance of the FFY 2006 PERM methodologies employed by KHPA including provider education and communications. KHPA will be selected for PERM again in FFY 2009.

6. Using Targeted Case Managers to Improve Preventative Health Care In the Disabled Medicaid Population

Persons with disabilities are generally less likely to receive age and gender appropriate preventive health care services such as Pap smears, mammograms, and dental care. However, disabled persons have higher rates of chronic medical co-morbidities than their peers, with rates approaching those of the aged population. Disabled persons also fare poorly when it comes to management of their chronic conditions. Given their close relationships with beneficiaries, it seems reasonable to assume that case managers, with the appropriate resources, can intervene to improve the receipt of quality preventive health care. We propose to provide case managers in pilot sites with a computerized, claims-based querying system (Impact Pro from Ingenix Public Sector Solutions, Inc.) and attendant algorithms that will allow them to ascertain the history of, and need for, preventive health care services for the beneficiaries they serve. Using these algorithms, they will be able to communicate with beneficiaries and their clinical providers the necessity and importance of quality care and improve beneficiaries' health. By providing targeted case managers the Impact Pro tool to use Medicaid claims data to ensure screenings and preventive care opportunities are not missed, overall health outcomes should improve – resulting in savings to the Kansas Medicaid program. Effectiveness of the case manager intervention will be determined at the Center level based upon the proportions of their caseloads who receive the requisite screenings, where appropriate, and the level of monitoring of chronic conditions, also as appropriate. The two-year total budget request is $906,664.